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| Case Number: | CM15-0121828 | | |
| Date Assigned: | 07/09/2015 | Date of Injury: | 07/08/1993 |
| Decision Date: | 08/26/2015 | UR Denial Date: | 06/17/2015 |
| Priority: | Standard | Application Received: | 06/24/2015 |

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, California

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 51 year old female, who sustained an industrial injury on 07/08/1999. Initial complaints and diagnosis were not clearly documented. On provider visit dated 06/05/2015 the injured worker has chronic low back pain. The injured work was note to be status post two lumbar fusions 1999 and 2011. On the right lower extremities was noted to a decreased strength and lumbar spine was noted to have spasms and guarding. The diagnoses have included degeneration lumbar or lumbosacral intervertebral disc disease. Treatment to date has included status post spinal cord stimulator trial and medication. The provider requested retrospective Avinza, Baclofen, Endocet and Gabapentin. The medication list include Avinza, Baclofen, Endocet, Prevacid and Trazodone and Gabapentin. The patient has had MRI of the lumbar spine on 3/2/12 that revealed disc protrusions, and foraminal narrowing and MRI of the thoracic spine on 1/11/15 that revealed degenerative changes. The patient underwent SCS trial on 4/14/15. The patient's surgical history include left wrist and lumbar spine surgery. A recent urine drug screen report was not specified in the records provided.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Retro Avinza 60 MG Qty 30 Refills Not Specified: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines -Opioids, criteria for use Page(s): 76-80.

Decision rationale: According to CA MTUS guidelines cited below, "A therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Other criteria for ongoing management of opioids are: The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects." On provider visit dated 06/05/2015 the injured worker has chronic low back pain. The injured work was note to be status post two lumbar fusions 1999 and 2011. On the right lower extremities was noted to a decreased strength and lumbar spine was noted to have spasms and guarding. The diagnoses have included degeneration lumbar or lumbosacral intervertebral disc disease. The patient has had MRI of the lumbar spine on 3/2/12 that revealed disc protrusions, and foraminal narrowing and MRI of the thoracic spine on 1/11/15 that revealed degenerative changes. The patient underwent SCS trial on 4/14/15. She states the pain is unbearable and interferes with her daily activity and sleep. The pt has been prescribed a opioid in a small quantity. Non opioid measures for pain control (gabapentin) are being tried as well. This medication is deemed medically appropriate and necessary in the present dose and amount The medication Retro Avinza 60 MG Qty 30 (Refills Not Specified) is medically necessary and appropriate in this patient.

Retro Baclofen 10 MG Qty 90 Refills Not Specified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

Decision rationale: According to California MTUS, Chronic pain medical treatment guidelines, Baclofen, "is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Any evidence of spasticity related to multiple sclerosis and spinal cord injuries was not specified in the records provided." California MTUS, Chronic pain medical treatment guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. Per the guideline, muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Sedation is the most commonly reported adverse effect of muscle relaxant medications. Patient had a chronic injury and any evidence of

acute exacerbations in pain and muscle spasm was not specified in the records provided. Per the doctor's note dated 07/23/14 physical examination of the low back revealed full strength, normal gait and sensation. The date of injury for this patient is 07/08/1999. As the patient does not have any acute pain at this time, the use of muscle relaxants is not supported by the CA MTUS chronic pain guidelines. Furthermore as per guidelines skeletal muscle relaxants show no benefit beyond NSAIDs in pain and overall improvement. Therefore the medical necessity of Retro Baclofen 10 MG Qty 90 Refills Not Specified is not established for this patient.

Retro Endocet 10-325 MG Qty 180 Refills Not Specified: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines -Opioids, criteria for use: page 76-80 Page(s): 76-80.

Decision rationale: According to CA MTUS guidelines cited below, a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. Other criteria for ongoing management of opioids are: The lowest possible dose should be prescribed to improve pain and function. Continuing review of the overall situation with regard to nonopioid means of pain control. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. On provider visit dated 06/05/2015 the injured worker has chronic low back pain. The injured work was note to be status post two lumbar fusions 1999 and 2011. On the right lower extremities was noted to a decreased strength and lumbar spine was noted to have spasms and guarding. The diagnoses have included degeneration lumbar or lumbosacral intervertebral disc disease. The patient has had MRI of the lumbar spine on 3/2/12 that revealed disc protrusions, and foraminal narrowing and MRI of the thoracic spine on 1/11/15 that revealed degenerative changes. The patient underwent SCS trial on 4/14/15. She states the pain is unbearable and interferes with her daily activity and sleep. Non opioid measures for pain control (gabapentin) are being tried as well. This medication is deemed medically appropriate and necessary in the present dose and amount to treat any exacerbations of the pain on an as needed/ prn basis. The medication Retro Endocet 10-325 MG Qty 180 Refills Not Specified is medically necessary and appropriate in this patient.

Retro Gabapentin 600 MG Qty 120 Refills Not Specified: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18.

Decision rationale: According to the CA MTUS Chronic pain guidelines regarding Neurontin/ gabapentin, 'has been shown to be effective for treatment of diabetic painful neuropathy and

postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain'.
Spinal cord injury: Recommended as a trial for chronic neuropathic pain Lumbar spinal stenosis:
Recommended as a trial, with statistically significant improvement found in walking distance,
pain with movement, and sensory deficit. This medication appears to be effective in reducing
abnormal hypersensitivity (allodynia and hyperalgesia), to have anti-anxiety effects, and may be
beneficial as a sleep aid. On provider visit dated 06/05/2015 the injured worker has chronic low
back pain. The injured work was note to be status post two lumbar fusions 1999 and 2011. On
the right lower extremities was noted to a decreased strength and lumbar spine was noted to have
spams and guarding. The diagnoses have included degeneration lumbar or lumbosacral
intervertebral disc disease. The patient underwent SCS trial on 4/14/15. The patient has chronic
pain with a neuropathic component. The patient has abnormal objective findings that are
consistent with the patient symptoms. Anticonvulsants or antiepileptics like gabapentin/
Neurontin are medically appropriate and necessary in this patient. The cited guidelines support
the use of Retro Gabapentin 600 MG Qty 120 Refill Is Not Specified in patients with this clinical
situation, therefore the request is deemed medically necessary.